

US Family Health Plan

Prior Authorization Request Form for rifaximin (**Xifaxan**) 200mg

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Approval is for one fill.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the use for treatment of traveler's diarrhea caused by noninvasive strains of E. coli?	<input type="checkbox"/> Yes Proceed to Question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the patient 12 years of age or older?	<input type="checkbox"/> Yes Proceed to Question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have diarrhea complicated by fever or bloody stool?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to Question 4
4. Does the patient have diarrhea due to pathogens other than noninvasive strains of E. coli?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to Question 5
5. Has the patient tried and failed a 3-day trial of ciprofloxacin or is ciprofloxacin contraindicated?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to Question 6
6. Has the patient tried and failed azithromycin or is azithromycin contraindicated?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

[†] Coverage is NOT provided for the treatment of other conditions not listed above, including: diarrhea complicated by fever or bloody stool, dysentery, diarrhea associated with use of antibiotics, diarrhea caused by bacteria other than E. coli, C. difficile infection, irritable bowel syndrome, inflammatory bowel disease, chronic abdominal pain, hepatitis, diabetes, rosacea, or any other non-FDA approved use.

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature	_____ Date
-------------------------------	---------------